GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

BOARD OF OCCUPATIONAL THERAPY

Supplement Information Form

NAME _____

____ OCCUPATIONAL THERAPIST

____ OCCUPATIONAL THERAPY ASSISTANT

1. Have you ever taken the AOTCB examination? ____ Yes ____ No

2. If "Yes", please give date and location of examination.

_____

3. Were your scores accepted as passing? ____ Yes ____ No

4. If you are AOTCB certified, please give certification number _____.

5. Please list below the location of all training and practice since date of graduation to the present date. Include periods of unemployment or other employment.

Name of Immediate Supervisor	Address (city/state)	Month/Year

(If additional space is needed, please attach on separate sheet of paper).